WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
COREEN ANN ELLIOTT, R.N., RESPONDENT.	:	0001995

Division of Legal Services and Compliance Case No. 17 NUR 021 and 17 NUR 358

The parties to this action for the purpose of Wis. Stat. § 227.53 are:

Coreen Ann Elliott, R.N.
953 Green Acres Drive
Sheboygan Falls, WI 53085-2541

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53708-8366

Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Wisconsin Board of Nursing (Board). The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent Coreen Ann Elliott, R.N., (D.O.B. October 26, 1980) is licensed in the state of Wisconsin as a registered nurse, having license number 161594-30, first issued on February 11, 2008 and current through February 28, 2020. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 953 Green Acres Drive, Sheboygan Falls, Wisconsin 53085-2541.

2. On August 16, 2012, the Board issued a Final Decision and Order (Order No. 0001995) limiting Respondent's registered nursing license for discrepancies involving administration of a controlled substance. Her license was limited as follows:

a. Respondent shall complete six (6) hours of education on the topic of medical administration.

b. Respondent shall not consume any controlled substance listed in Schedule I-IV without a valid prescription and for a valid medical purpose.

c. Upon a request from the Board, Respondent shall submit to a drug screen.

d. Respondent shall work under direct supervision by an employer pre-approved by the Board.

e. Respondent shall arrange for quarterly reports from her nursing employer(s) reporting the terms and conditions of her employment and evaluating her work performance.

3. On June 11, 2015, the Board issued a Final Decision and Order (Order No. 0004057) suspending Respondent's professional nursing license for discrepancies associated with administration and documentation of controlled substances that occurred in October of 2014.

4. On October 16, 2015, the suspension associated with Board Order No. 0004057 was terminated after Respondent showed proof of completion of the required education on documentation, medication, professional accountability, and critical thinking.

5. On February 9, 2017, the Board considered Respondent's request to remove the limitations on her license set forth in Board Order No. 0001995. The Board denied the request, as Respondent failed to demonstrate continuous and successful compliance.

6. On October 11, 2018, the Board found that Respondent violated Board Order No. 0001995 by consuming a Schedule IV controlled substance without a valid prescription by an authorized prescriber. Respondent's license was suspended and limited requiring successful compliance with the terms and conditions for five years.

7. On December 14, 2018, the suspension was stayed.

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8. Between February and October 2016, Respondent was employed as a registered nurse at a care facility (Facility), located in Sheboygan Falls, WI.

9. On September 23, 2016, Respondent destroyed thirty-six (36) hydrocodone-acetaminophen tablets.

10. Respondent and Nurse A's initials are on the medication log, which serves as documentation for the destruction of the hydrocodone-acetaminophen tablets. Nurse A asserted that she did not witness the destruction and that her initials were forged.

11. Respondent admitted to destroying medications on multiple occasions without a witness, which was in opposition to the Facility's policy on destruction of medication.

12. Between September 17 and September 23, 2016, Respondent signed out one (1) oxycodone 10 mg tablet for Patient A on seventeen (17) occasions. Respondent failed to document administering the medication nine (9) of the seventeen (17) occasions.

13. Patient A was prescribed one (1) oxycodone 10 mg tablet as needed every four (4) hours. On September 19, 2016, Respondent signed out one (1) oxycodone for Patient A at 2 p.m. within the prescribed order. She signed out one (1) oxycodone 10 minutes later for Patient A outside of the prescribed order. Neither tablet was recorded as administered.

14. Between September 17 and September 23, 2016, Respondent signed out one (1) hydrocodone-acetaminophen 5-325 mg tablet for Patient B on fifteen (15) occasions. Respondent failed to document administering the medication on eleven (11) of the fifteen (15) occasions.

15. Patient B was prescribed one (1) tablet of hydrocodone-acetaminophen 5-325 mg tablet as needed every four (4) hours. On multiple occasions, Respondent gave Patient B the medication more frequently than the medication order stated.

16. Between September 13 and September 23, 2016, Respondent signed out one (1) hydrocodone-acetaminophen 5-325 mg tablet for Patient C on fourteen (14) occasions. Respondent failed to document administering to the patient six (6) of the fourteen (14) occasions. Respondent documented administering the medication prior to dispensing the medication on five (5) occasions.

17 NUR 358

17. Between February and June 2017, Respondent was employed as a registered nurse at a medical and rehabilitation center (Center), located in Manitowoc, Wisconsin.

18. On May 27, 2017, the Center discovered that a narcotic card containing fourteen (14) oxycodone was missing.

19. The Center began reviewing narcotic cards, pain flow sheets, and medication administration records for leads regarding the missing pills. The Center's investigation uncovered multiple discrepancies with Respondent's administration and documentation.

20. On May 27, 2017, the Center requested that Respondent submit to a urine drug screen.

21. The immediate results of the urine drug screen were positive for opiates and oxycodone. Respondent stated that she was taking Vicodin®.

22. After questioning Respondent, the Center suspected diversion and requested that Respondent submit to a second urine drug screen. Respondent refused and resigned from her position.

23. Respondent provided the Department with a prescription from February 6, 2017, consisting of ten (10) tablets of hydrocodone-acetaminophen 5-325 mg. She asserted the prescription was from an oral surgery for which she had not used all of the medication.

24. The Center discovered multiple discrepancies regarding Respondent's documentation and administration of controlled substance medication. This included:

a. On May 27, 2017, Respondent signed out one (1) hydrocodone-acetaminophen 5-325 mg tablet for Resident D without a physician order. There was no administration record, and Resident D stated she did not take pain medication on this day.

b. On May 27, 2017, Respondent signed out two (2) oxycodone-acetaminophen 5-325 mg tablets at 8:00 a.m. and 2:00 p.m. for Resident E. Respondent did not document administering the medication. Resident E stated she did not receive pain medication.

c. On May 27, 2017, Respondent signed out two (2) hydrocodone-acetaminophen 5-325 mg tablets for Resident F at two (2) separate times. Respondent failed to document administering the medication. Resident F asserted that she did not receive pain medication.

d. On May 27, 2017, Respondent signed out medications for Patient G on two (2) separate narcotic cards. The order was for one (1) hydrocodone-acetaminophen 5-325 mg tablets twice a day. Respondent signed out one (1) hydrocodone-acetaminophen on a narcotic card at 9:00 a.m. and two (2) hydrocodone-acetaminophen on a different narcotic card also at 9:00 a.m. Respondent documented that the morning dose was administered. Respondent also signed out one (1) hydrocodone at noon and another at one. These were documented on two (2) separate narcotic cards. Respondent failed to make a record of administering these tablets.

25. In resolution of 17 NUR 021 and 17 NUR 358, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter pursuant to Wis. Stat. § 441.07, and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. By the conduct described in the Findings of Fact, Coreen Ann Elliott, R.N., violated Wis. Admin. Code § N 7.03(6)(a), by failing to perform nursing with reasonable skill and safety.

3. By the conduct described in the Findings of Fact, Coreen Ann Elliott, R.N., violated Wis. Admin. Code § N 7.03(6)(c), by departing from or failing to conform to the minimal standards of acceptable nursing practice.

4. By the conduct described in the Findings of Fact, Coreen Ann Elliott, R.N., violated Wis. Admin. Code § N 7.03(8)(c), by administering any drug other than in the course of legitimate practice.

5. By the conduct described in the Findings of Fact, Coreen Ann Elliott, R.N., violated Wis. Admin. Code § N 7.03(8)(d), by improper administering of medication.

6. As a result of the above conduct, Coreen Ann Elliott, R.N., is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (d).

ORDER

1. The attached Stipulation is accepted.

2. The SURRENDER of the license and privilege of Coreen Ann Elliott, R.N., (license no. 161594-30) to practice nursing in the state of Wisconsin or under another state license pursuant to the Enhanced Nurse Licensure Compact is hereby accepted.

3. In the event Respondent petitions the Board of Nursing for reinstatement as a nurse in the future, the Board may enter an order denying such application without further notice or hearing. Whether to grant a license and whether to impose any limitations or restrictions on any license granted shall be in the discretion of the Board.

4. In the event that Respondent petitions for reinstatement of her nursing license, or applies for any license with the Department of Safety and Professional Services, she must immediately pay costs of this matter in the amount of $3,153.00. The costs must be paid before the Board will consider her petition for reinstatement.

5. If applicable, payment of costs shall be made payable to Wisconsin Department of Safety and professional services and sent to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

You may also submit this information online via DSPS' Monitoring Case Management System, here:

https://app.wi.gov/DSPSMonitoring

4. This Order is effective on the date of its signing.

WISCONSIN BOARD OF NURSING

by: _____ 5/9/19
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	STIPULATION
COREEN ANN ELLIOTT, R.N., RESPONDENT.	:	0006154

Division of Legal Services and Compliance Case No. 17 NUR 021 and 17 NUR 358

Respondent Coreen Ann Elliott, R.N., and the Division of Legal Services and Compliance, Department of Safety and Professional Services stipulate as follows:

1. This Stipulation is entered into as a result of a pending investigation by the Division of Legal Services and Compliance. Respondent consents to the resolution of this investigation by Stipulation.

2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Respondent, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Respondent;
- the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
- the right to testify on Respondent's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Respondent is aware of Respondent's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Board of Nursing (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the Division

of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

8. The Division of Legal Services and Compliance joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

Coreen Ann Elliott, R.N., Respondent
953 Green Acres
Sheboygan Falls, WI 53085-2541
License no. 161594-30

3/11/2019
Date

Elizabeth K. Bronson, Attorney
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison WI 53707-7190

3/14/19
Date